



Testimony

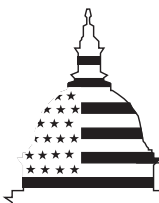
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VA AND DOD HEALTH CARE

Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss factors that have contributed to reduced pharmacy costs in the Department of Veterans Affairs (VA) and the Department of Defense (DOD) and continuing challenges the departments face. Since the early 1980s, the Congress has had a particular interest in having VA and DOD achieve greater efficiencies through increased collaboration. These two departments combined spent about \$3.2 billion on pharmaceuticals for their beneficiaries in fiscal year 2000.¹ These pharmacy expenditures are primarily for prescription drugs and their dispensing but also include some supplies and over-the-counter drugs. Reflecting national trends, VA and DOD pharmacy expenditures have risen significantly, consuming an increasing percentage of the departments' health care budgets. The increase in pharmacy costs would have been even greater if not for the efforts taken by VA and DOD to avoid additional pharmacy costs.

In my remarks today, I will discuss factors that have contributed to reduced pharmacy spending in VA and DOD and the continuing challenges these departments face. My comments are based on work we have previously done for you and other congressional requesters.² As part of that work, we used VA and DOD's definition of cost avoidance to describe potential savings from their joint procurement or purchasing efforts to contract for drugs from manufacturers. The departments define cost avoidance as the difference between the theoretical cost that would have occurred if contracts were not awarded and the actual cost incurred for the drugs affected by each contract.

In summary, we identified four important factors that have contributed to reduced pharmacy spending in VA and DOD. First, the two departments have used formularies to encourage the substitution of a lower-cost drug that is determined to be just as effective as a higher-cost drug. Second, VA and DOD have been able to effectively employ different arrangements to pay for or purchase prescription drugs at substantial discounts. Third, VA has significantly reduced the cost of dispensing prescription refills by using highly automated and less expensive consolidated mail outpatient pharmacy (CMOP) centers to handle a majority of the pharmacy workload

¹In addition, DOD's TRICARE health program spent \$455 million on prescriptions filled for beneficiaries at retail pharmacies in fiscal year 2000.

²See related GAO products at the end of this statement.

instead of VA hospital and clinic pharmacies. Fourth, VA and DOD have reduced costs by leveraging their combined purchasing power by jointly buying prescription drugs. Nevertheless, VA and DOD face continuing challenges in reducing pharmacy costs. One of the most important challenges is the joint procurement of brand name drugs. Although brand name prescription drugs account for the bulk of prescription drug expenditures, most of VA/DOD joint contracts have been for generic drugs. Generic drugs are easier to contract for because these products are already known to be chemically and therapeutically alike. Contracting for brand name drugs is more difficult because of the scientific reviews needed to gain clinical agreement on therapeutic equivalence of competing drugs. Joint purchasing of brand name drugs also is more difficult due to the significant differences between the VA and DOD health care systems. These include differences between the systems in patient populations, national formularies, and prescribing patterns of providers, some of whom are private physicians.

Background

The Congress has urged VA and DOD to work together to maximize the efficiency and effectiveness of federal health care resources they use for pharmacy and other services.³ In May 1982, the Congress passed the VA and DOD Health Resources Sharing and Emergency Operations Act (P.L. 97-174), which generally encouraged the two departments to enter into agreements to share health care services. Beginning in the mid-1990s, the Congress increasingly emphasized that the departments cooperate in the purchase and distribution of pharmaceuticals. A 1999 report by a congressional commission concluded that VA and DOD should combine their market power to get better pharmaceutical prices through joint contracts.⁴ More recently, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) required VA and DOD to submit a report on how joint pharmaceutical procurement can be enhanced and cost

³In fiscal year 2000, VA purchased 86 million prescriptions for veterans. Also in that year, DOD purchased 54 million military pharmacy and mail-order prescriptions for active duty and retired military service members and their families. In addition, TRICARE's health program paid for 12 million prescriptions for beneficiaries at retail pharmacies.

⁴*Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance*, Anthony J. Principi, Chairman (Arlington, Va. Congressional Commission on Servicemembers and Veterans Transition Assistance, Jan. 14, 1999).

reductions realized.⁵ Finally, the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) included a provision encouraging VA and DOD to increase to the maximum extent consistent with their respective missions their level of cooperation in the procurement and management of prescription drugs.

Factors Contributing to Reduced Pharmacy Costs

We identified four factors that have contributed to VA's and DOD's success in reducing pharmacy costs:

- Formularies to substitute cost-effective drugs
- Different types of purchasing arrangements to secure lower prices
- Mail-order dispensing to refill prescriptions
- Joint purchasing of prescription drugs to leverage purchasing power

Drug Formularies Help to Reduce Drug Costs

VA and DOD have been able to reduce spending on drugs by establishing formularies. VA and DOD can increase their savings by using one or more of the lower cost drugs from their formularies in drug classes that they have determined are therapeutically interchangeable—that is, essentially equivalent in terms of efficacy, safety, and outcomes. In these cases, VA and DOD place restrictions on providers' choice of drug, by classifying a drug class as either closed or preferred. In the closed classes, VA providers must prescribe and pharmacies must dispense the selected drug, instead of therapeutic alternatives. Case-by-case exceptions for nonformulary prescriptions are allowed. VA has classified about 2 percent of the classes on VA's national formulary as closed or preferred. VA obtains more favorable prices for some drugs in the closed classes by competitively awarding contracts that guarantee companies a high volume of use.⁶ In preferred classes, VA and DOD providers and pharmacies are encouraged to use the preferred drug but may prescribe or dispense other drugs in the same class without obtaining an exception.

VA has been able to control costs by encouraging their providers to use drugs on their formulary without having adverse effects on health care

⁵In January 2001, VA and DOD submitted this report, which detailed ongoing efforts to share information, work, ideas, and requirements toward maximizing efficiencies in their health care systems. See VA and DOD, *Report on Implementation of Section 210 of the "Veterans Millennium Health Care and Benefits Act" – P.L. 106-117* (Washington, D.C.: U.S. Government Printing Office, Jan. 4, 2001).

⁶VA and DOD refer to these as committed-use contracts.

quality, according to an Institute of Medicine (IOM) study.⁷ The IOM study noted that formularies are a key part of modern health care systems and that VA's formulary was well managed and not overly restrictive. IOM recommended that VA continue to prudently establish closed and preferred classes of drugs on its formulary and to use more contracts to carefully limit drug choices in more classes, based on quality and cost considerations.

Departments Use Several Purchasing Arrangements to Obtain Lower Drug Prices

VA and DOD have been successful in using a number of purchasing arrangements to obtain substantial discounts on prescription drugs (see table 1). For the bulk of their pharmaceutical purchases, VA and DOD obtain favorable prices through the Federal Supply Schedule (FSS). By statute,⁸ in order to be able to obtain reimbursement for drugs for Medicaid beneficiaries, manufacturers must offer their drugs on the FSS. The FSS schedule prices are intended to be no more than the prices manufacturers charge their most-favored nonfederal customers under comparable terms and conditions. In 1999, about 81 percent of VA and DOD's combined \$2.4 billion in drug expenditures was for drugs bought through the FSS for pharmaceuticals.

⁷Dave Blumenthal and Roger Herdman, eds., *Description and Analysis of the VA National Formulary*, IOM, Division of Health Care Services, VA Pharmacy Formulary Analysis Committee (Washington, D.C.: National Academy Press, 2000).

⁸38 U.S.C. § 8126(a)(4).

Table 1: VA and DOD Pharmaceutical Purchasing Arrangements

Purchasing arrangements	Description	Discount
FSS for pharmaceuticals	VA negotiates contracts with drug companies to set prices available to all federal purchasers. FSS prices are intended to be no more than the prices manufacturers charge their most-favored nonfederal customers under comparable terms and conditions. Under federal law, ^a drug manufacturers must list their brand name drugs on the FSS to receive reimbursement for drugs covered by Medicaid.	About 50 to 58 percent lower than average wholesale price. ^b
Federal ceiling price for pharmaceuticals	VA, DOD, Public Health Service (PHS), and the Coast Guard can purchase at the Federal Ceiling Price (FCP), which must be at least 24 percent lower than the nonfederal average manufacturer price (NFAMP). The NFAMP is the average price paid to a manufacturer by wholesalers for drugs distributed to nonfederal purchasers.	FCP price is lower than the FSS price for many drugs.
FSS blanket purchase agreements (BPA)	FSS contracts with drug manufacturers contain BPA provisions so that VA and DOD can negotiate additional discounts. Sometimes the lower prices are dependent on specific volumes being purchased by particular facilities, such as one or more VA or military hospitals. VA and DOD have negotiated a few BPAs for preferred status on their respective national formularies.	Variable discounts below FSS prices.
Requirements contracts	VA and DOD brand name drug and generic drug requirements contracts differ as follows.	Average 33 percent lower than FSS prices.
	<p>After performing drug class reviews, VA and DOD determine that some brand name drugs are therapeutic alternatives. This determination allows VA and DOD to conduct a competition among the equivalent drugs and to select one winner based on price alone. VA and DOD commit to use the selected drug on their respective national formularies and close the class to other therapeutic alternatives. Providers must prescribe and VA and DOD pharmacies must dispense the contract drug, instead of therapeutic alternatives, to guarantee drug companies a high volume of use. Case-by-case exceptions are allowed under certain circumstances, such as for medical necessity.</p>	
	<p>In some cases, brand name drug requirements contracts are also based on competitions among drugs that have been determined to be therapeutic alternatives. Here, however, VA and DOD list the contracted drugs as preferred agents on their respective national formularies, but do not close the class. Individual VA and military pharmacies may add and use other drugs in the same class on their local formularies.</p>	
	<p>For generic drugs, VA and DOD conduct a competition for an exclusive contract with one manufacturer. Contracted items are usually selected from among generic products approved by the Food and Drug Administration that are tested against a standard of bioequivalence to the original brand name version.</p>	

^a38 U.S.C. § 8126(a)(4).

^bThe average wholesale price (AWP) is a price assigned by the product's manufacturer and may be neither "average" nor "wholesale." Instead, the AWP is often described as a "list price," "sticker price," or "suggested retail price." The term AWP is not defined in law or regulation, so the manufacturer is free to set an AWP at any level, regardless of the actual price paid by purchasers.

Sources: U.S. General Accounting Office, Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes, GAO/HEHS-00-118 (Washington, D.C.: Aug. 7, 2000), U.S. General Accounting Office, Medicare Part B Drugs: Program Payments Should Reflect Market Prices, GAO-01-1142T (Washington D.C.: Sept. 21, 2000), and GAO analysis of VA and DOD information.

VA and DOD also buy some brand name drugs for prices less than those listed under the FSS schedule. For example, by statute VA and DOD can buy brand name drugs at a price at least 24 percent lower than the nonfederal average manufacturer price (NFAMP), which may be lower than the FSS price for many drugs.⁹ In addition, VA and DOD have obtained some drugs at lower than FSS prices through national contracts with a single manufacturer based on a competitive-bid process. VA and DOD may solicit competitive bids for therapeutically equivalent drugs and may select one winner based on price alone for exclusive or preferred use on their formularies. These competitive processes for formulary drugs result in prices that average 33 percent lower than FSS prices.

Consolidated Mail Outpatient Pharmacies Reduce Drug Refill Costs

VA has used consolidated mail outpatient pharmacy (CMOP) centers to reduce dispensing costs. CMOPs reduce costs through economies of scale.¹⁰ Specifically, CMOP automated technologies have enabled each full-time CMOP employee to dispense between 50,000 and 100,000 prescriptions annually, compared to about 15,000 prescriptions dispensed by VA pharmacy employees. According to VA, such productivity rates are several times greater than traditional hospital and clinic systems. As a result of these automated technologies, VA estimated that its dispensing cost per prescription for CMOPs was approximately \$2.00 in fiscal year 2000. VA and DOD are currently working on a pilot demonstration to test the feasibility of DOD using VA's CMOPs to assume refill prescription workload from military pharmacies.

In addition to reducing dispensing costs, additional benefits could result because VA's CMOPs have reduced the pharmacy workload of VA hospital and clinic pharmacies. Between 1996 and 2000, the CMOPs have increased their prescription processing by 30 percent per year. Instead of patients

⁹The NFAMP is the weighted average price of each single form and dosage unit of a drug that is paid to a manufacturer by wholesalers for nonfederal purchasers, taking into account any cash discounts or similar price reductions.

¹⁰Since 1994, VA has established seven CMOPs. These are located in Bedford, Mass.; Charleston, S.C.; Dallas, Tex.; Hines, Ill.; Leavenworth, Kan.; Los Angeles, Calif.; and Murfreesboro, Tenn.

receiving prescriptions from VA hospitals or clinics, the CMOPs process and mail out the prescriptions. Patients generally receive their medications by mail within 4 days of their orders going from the VA medical facility to a CMOP. As a result of this reduction in pharmacy volume at VA hospital and clinic pharmacies, VA can potentially operate with fewer pharmacists and other staff, free-up more of pharmacists' time to counsel patients, and reduce waiting times for beneficiaries in VA hospital and clinic pharmacies.

VA and DOD Joint Purchasing Efforts Obtain Additional Savings

While VA and DOD have obtained prices that are better than the FSS through negotiating contracts, they have secured additional savings through joint procurement. In 2001, VA and DOD estimated substantial savings from current and planned joint procurements of pharmaceuticals—about \$170 million per year.¹¹ The departments can exert considerable leverage when they commit to buy increased volumes of particular generic or brand name drugs that are interchangeable in efficacy, safety, and outcomes. For example, from October 1998 through April 2000, VA and DOD awarded joint contracts for 18 products, which accounted for about \$62 million in combined drug expenditures in fiscal year 2000. Although these drugs accounted for just 1.9 percent of the departments' combined \$3.2 billion drug spending in 2000, VA and DOD estimate these joint procurement discounts achieved sizeable cost avoidance—about \$40 million in 2000.

Most VA and DOD joint procurements have been for low-cost generic drugs. VA and DOD have experienced difficulties in joint contracting for brand name drugs because limiting beneficiary choice requires gaining clinical agreement on therapeutic equivalence of competing drugs. Due to the complexity of the care issues and the need to garner clinical acceptance and support, VA and DOD can take as long as a year between the date their respective class reviews establish therapeutic equivalence of competing brand name drugs and the date a contract is awarded. Generic drug contracts do not require drug class reviews—since competing products are already known to be chemically and therapeutically alike—and, therefore, take less effort and time—about 120 days.

¹¹The departments estimated the theoretical cost by multiplying the weighted average price per unit before the contract took effect, by the quantity purchased in fiscal year 2000. For example, the departments' estimated cost avoidance for cholesterol-lowering drugs takes account of expenditures for all six such brand name drugs, not just the two for which each department has contracted. In our view, this is a reasonable estimating methodology.

VA and DOD have demonstrated that in a few cases, with flexible arrangements, they can procure brand name drugs at maximum discounts while still allowing one or both departments to preserve drug choice. For example, DOD negotiated a blanket purchase agreement (BPA) to receive the same price as VA's contract price for Zoladex—a 33-percent discount off of old prices¹² for the leutinizing hormone–releasing hormone (LHRH) class of anticancer drugs.¹³ In return, DOD has agreed to the preferential use of Zoladex to treat a subset of DOD's population—adult prostate cancer patients. However, the BPA does not limit providers' choice in prescribing LHRH drugs for women and children.¹⁴

Continuing Challenges for Reducing Pharmacy Cost

VA and DOD face continuing challenges to reduce future drug costs. One of the most important challenges is the joint procurement of brand name drugs. VA and DOD officials state that it is more difficult to restrict brand name drugs on their formularies than generic drugs. As discussed earlier, garnering clinical support and provider acceptance on certain brand name drugs is more difficult because of the scientific reviews needed to gain clinical agreement on therapeutic equivalence of competing drugs. As a result, most VA and DOD joint procurements have been for low-cost generic drugs. However, because brand name drugs make up a far higher share of expenditures than generic drugs, the financial benefit of more joint procurement of brand name drugs is much greater. For example, VA's brand name drug purchases are 36 percent of volume but 91 percent of expenditures.¹⁵

The joint purchase of brand name drugs is further complicated due to the significant differences between the VA and DOD health care systems. These include differences in patient populations. VA serves mostly older

¹²FSS contracts contain BPA provisions so that DOD can negotiate additional discounts in return for specific volumes being purchased by military hospitals. To retain the 33 percent discount below prior DOD prices, the Zoladex BPA calls for achieving an overall military pharmacy market share of 80 percent of prescriptions for adult prostate cancer patients (age 18 years and older) by September 2001.

¹³The LHRH class includes goserelin (Zoladex) and leuprolide (Lupron).

¹⁴In addition to being used to treat prostate cancer, LHRH drugs may also be used to treat breast cancer, endometriosis, and precocious puberty.

¹⁵According to DOD, an estimated 40 percent of military pharmacists' prescription volume in 1999 and 2000 was for brand name drugs; however, data are unavailable on DOD brand name versus generic drug costs.

men, while DOD also serves younger men as well as women and children. VA and DOD officials state that different populations result in dissimilar patterns of drug use and demand among their respective beneficiaries, resulting in fewer opportunities to combine drug requirements and solicit joint contracts. However, increasing numbers of military retirees and expanded DOD benefits are lessening differences between VA and DOD drug needs. In fiscal year 2000, close to 70 percent of military pharmacies' drug costs was for retirees' prescriptions.

Another difference between the two systems that complicates joint procurement efforts is the scope of VA's and DOD's formularies. In 2001, VA's national formulary listed about 1,100 drugs for inpatient and outpatient care representing 254 classes, while DOD's basic core formulary listed 175 drugs for outpatient care in only 71 classes. VA's national formulary was supplemented by 22 regional formularies of its health care networks. In addition, DOD's hospitals, its national mail pharmacy, and its retail pharmacy networks maintain their own separate formularies. The different scope of the formularies complicates VA and DOD's efforts to find overlap between the formularies. In an effort to address differences in DOD's formularies, the Congress passed legislation in 1999 requiring DOD to establish a uniform drug formulary by October 2000, applicable to both military pharmacies and TRICARE retail and mail-order pharmacies.¹⁶ DOD issued a proposed rule to establish a uniform formulary in April 2002, but this rule has not been finalized.

Finally, differences in prescribing patterns of providers further complicate joint procurement. DOD is concerned about its ability to control private-provider prescribing practices and persuade these providers to prescribe drugs contracted under joint procurements. Unlike VA beneficiary prescriptions, which are almost all written by VA providers and dispensed by VA pharmacies, DOD beneficiary prescriptions are written by both military and private providers and dispensed by both military and retail pharmacies. For example, about half of the 52 million prescriptions dispensed by military pharmacies in fiscal year 2000 were written by nonmilitary providers treating DOD beneficiaries.

¹⁶ 10 U.S.C. § 1074g.

Concluding Observations

VA and DOD have faced continuing pressure on their health care budgets from rapidly rising pharmacy costs. As in the private sector, these costs have risen faster than overall health care spending for the two departments. VA and DOD have taken a number of actions separately and jointly to attempt to restrain pharmacy costs. These actions include the establishment of formularies, use of different contract arrangements to purchase drugs, use of mail order pharmacies, and use of joint procurement. Nonetheless, VA and DOD face continuing challenges as pharmacy cost pressures continue unabated. One of these challenges is to increase joint purchasing of brand name drugs, which account for most pharmacy costs. To do this, the two departments need to address how differences in their respective patient populations, national formularies, and practice patterns among prescribers, some of whom are private physicians, can be managed to facilitate joint purchasing. Effectively doing so will be crucial for both VA and DOD to maintain control of their overall health care budgets.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the Subcommittee may have.

Contacts and Acknowledgments

For further information please contact me at (202) 512-7101 or James Musselwhite at (202) 512-7259. Thomas Walke also contributed to this statement.

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